Corporation for NATIONAL & COMMUNITY SERVICE

AmeriCorps*VISTA
AmeriCorps*NCCC

OTHER HEALTH COVERAGE QUESTIONNAIRE

In order to accurately process your claims and ensure that you receive the maximum benefits available, information regarding other health care coverage is needed. Please complete the information below, sign at the bottom of the form and return the form to the address below.

SECTION I: GENERAL INFORMATION

☐ **VISTA** ☐ **NCCC** **DOB:** _____

Cert Number: _____ **Social Security Number:** _____

Your Name: _____ **Telephone Number:** _____

Your Address: _____
Street City State Zip Code

Are you covered by any others health insurance? ☐ **Yes** ☐ **No**
If No, please skip to SECTION IV.

SECTION II: TYPE OF COVERAGE

Type of Coverage	Relationship to You
Health ☐ Group ☐ Individual	☐ Self ☐ Spouse ☐ Parent ☐ Other
Dental ☐ Group ☐ Individual	☐ Self ☐ Spouse ☐ Parent ☐ Other
Vision ☐ Group ☐ Individual	☐ Self ☐ Spouse ☐ Parent ☐ Other
☐ Medicare	☐ Self ☐ Spouse ☐ Parent ☐ Other

SECTION III: INFORMATION RELATED TO OTHER INSURANCE COVERAGE

_____ Policyholder Name
_____ Policyholder Social Security Number
_____ Policy Number

_____ Employer/Sponsoring Organization Name
___(_____)_____ Employer/Sponsoring Organization Telephone
_____ Policy Effective Date

_____ Employer Street Address
_____ City
_____ State
_____ Zip Code

_____ Name of Insurance Company
_____ Location of Insurance (City/State)
___(_____)_____ Insurance Company Telephone

SECTION IV: POLICYHOLDER SIGNATURE

I permit any physician, pharmacist, hospital or other health care provider, any insurer, prepayment organization or other health plan provider to give the Corporation for National Service any medical information about me, including information about physical and metal health, medical history, any drug or alcohol benefits.

This authorization shall remain in effect until all matters relating to these claims are concluded. A copy of this authorization will be as valid as the original. I understand that I may receive a copy of this authorization if I ask for one in writing.

_____ Policyholder Signature
_____/_____/_____ Date

Privacy Act Statement: This information is provided pursuant to Public Law 93-579 (Privacy Act of 1974) for AmeriCorps members completing Federal records and forms that solicit personal information. This authorization will be used to obtain information about an AmeriCorps member's medical history so that any medical claim filed by an AmeriCorps member can be processed expeditiously. No other uses will be made of this information. Effects of Non-Disclosure: Providing this information is voluntary; however, failure to authorize the release of any medical information may delay the processing of the medical claim.

Return completed form to: Seven Corners, Inc. P.O. Box 90260 Indianapolis, IN 46290-0260 866.699.4186 f. 317.575.2256